38.0.0 THIRD PARTY LIABILITY

38.1.0 Introduction

Third Party Liability (TPL) means that another party, not MA or the client, is obliged to pay the bills for a MA recipient's medical services.

MA is the payor of last resort for the cost of medical care. All MA clients must sign over to the State of Wisconsin their rights to payments for medical services from third party payors (including health insurers, court ordered medical support payments and any other third party payor.) A client complies with this requirement by signing the application form.

At application the Economic Support Agency (ESA) must give a Notice of Assignment (DWSW-2477) to each client. If the client refuses to sign this form, the ESA must complete the lower portion of the form and file it in the case record. Do this no later than at the time of the interview. Give the client a copy of the notice. Do not delay processing a Medicaid application while waiting for the form to be signed. Do not penalize the client for not signing this form. File the original in the case record.

38.2.0 HIPAA

HIPAA is the Health Insurance Portability and Accountability Act. A HIPAA Standard Plan is any group health care plan that provides medical care to covered individuals and/or their dependents directly or through insurance, reimbursement, or by some other means. Medical care means amounts paid for diagnosis, cure, mitigation (moderation), treatment or prevention of disease; or amounts paid for the purpose of affecting any structure or function of the body.

A policy that pays for a doctor's services in either an in-patient or outpatient setting qualifies as a HIPAA plan. The amount or type of benefits paid; co-insurance, deductibles, caps, etc., do not matter as long as the plan meets the HIPAA Standard Plan criteria.

The health care plan cannot be limited to a single type of covered service or only accessible in a very defined circumstance. Plans limited to accident, disability, vision, long term care or dental are **not** examples of HIPAA plans.

38.3.0 Reporting Other Health Insurance

Collect insurance coverage information at application, review, person add, or when insurance changes and enter it into CARES. EDS will complete an insurance search and return verified insurance information through the CARES/ MMIS interface.

38.3.1 Casualty Claims

Casualty claims are those claims for MA benefits resulting from an accident for which a third party may be liable.

> **Example.** Mike receives treatment for injuries suffered when he was hit by a car. The vehicle owner, the third party, may be responsible for reimbursing MA for those benefits.

The local Economic Support Agency (ESA) works with the Coordination of Benefits Unit to recover casualty claims.

The Coordination of Benefits Unit also recovers for MA recipients who are SSI recipients. Refer all SSI recipient casualty claims directly to the Coordination of Benefits Unit at:

Bureau of Health Care Systems and Operations
Coordination of Benefits Section
P.O. Box 309
Madison, WI 53701
Telephone: (608) 267-7282

38.3.2 Cooperation

The client must cooperate in providing TPL coverage and access information, unless s/he is exempt or there is good cause for refusing to cooperate.

If a caretaker refuses, without good cause, to provide health insurance information about a minor or dependent 18-year-old, the caretaker is ineligible until s/he cooperates.

Do not sanction the following for non-cooperation:

1. Minors, minor caretakers, and dependent 18-year-olds.

2. A caretaker requesting child support services for a child receiving SSI.

38.3.2 Cooperation (cont.)

3. Pregnant woman – She may not be sanctioned during the pregnancy or for two months after the pregnancy has ended if the TPL source is the absent parent of her child(ren).

38.3.3 Good Cause Claim

When good cause is claimed, review the circumstances and decide on whether it is an appropriate claim of good cause. Make the appropriate entry on CARES screen AFMC regarding the good cause determination, and note the reason for the decision in case comments.

38.3.4 BadgerCare

Collect all insurance coverage and access information for BadgerCare (BC) clients and enter into CARES. EDS will complete an insurance search and return the insurance information through the CARES/MMIS interface.

See 12.3.4 for when a client is ineligible for BadgerCare when there is insurance coverage.

38.3.5 Nursing Home and Hospital Insurance

All clients must cooperate in providing Third Party Liability (TPL) coverage and access information (38.2.0) for nursing home and hospital insurance policies (10.6.3.1). All clients must:

1. Sign over to the State of Wisconsin all their rights to payments from hospital or nursing home insurance (38.3.5.1).

2. Turn over any payments to the State of Wisconsin (38.3.5.2) that s/he received from nursing home or hospital insurance while receiving MA.

   Any nursing home or hospital insurance payments that exceed the amount that MA has paid in benefits for that client will be refunded to him/her.

Terminate MA eligibility for the individual who is not cooperating in providing TPL insurance information (38.3.2), unless they have good cause (38.3.3).

38.3.5.1 Assignment

To assign hospital or nursing home insurance payments, the client must provide a statement in writing to the insurance company requesting that all future payments be made to the State of Wisconsin. Request a copy of the client's letter to the insurance company and send it to the following address:

Wisconsin Medicaid
TPL Unit
6406 Bridge Road
Madison, WI 53784-6220

The assignment includes all ongoing payments for as long as MA is received.
Terminate MA eligibility for the individual that refuses to sign over these payments.

38.3.5.2 Recovery of Payments

In some cases, payments can only be signed over to the patient. The client must cooperate in turning over these payments to the State of Wisconsin, or his/her eligibility will end for not cooperating with providing TPL coverage and access information.

The client must write on the back of the check "Pay to the order of the State of Wisconsin" and sign the check.

Collect the payments monthly from the clients along with the corresponding Explanation of Benefits (EOB), and send them to the following address:

Wisconsin Medicaid
TPL Unit
6406 Bridge Road
Madison, WI 53784-6220

Close the case for non-cooperation with TPL requirements if the client refuses to turn over the payments.

38.4.0 Policies Not To Report

Do not enter the following policies on AFMI or AFMC in CARES, or report them to EDS on the Health Insurance Information form (DES 2096).

1. HMOs for which the State pays all or part of the premium.

2. Health Insurance Risk Sharing Plans (HIRSP).

38.4.0 Policies Not To Report (cont)

3. Medicare (enter in CARES on AFMD).
4. General Assistance Medical Program (GAMP).
5. Indian Health Service (IHS). IHS is the exception to the rule that MA is the payor of last resort. For Native Americans who are MA clients, IHS is the payor of last resort. Do not enter these policies on CARES.
6. Policies that pay benefits only for treatment of accidental injury.
7. Policies that may be described as health insurance, but which pay only weekly or monthly based on the insured's disability.
8. Limited insurance plans that pay only if there is a specific diagnosis, such as cancer policy. Report them only if the person insured has been diagnosed as having the disease s/he is insured against and if the benefits are assignable.
9. Life Insurance.
10. Other insurance types that do not cover medical services.

38.5.0 Insurance Through an Absent Parent

38.5.1 HMO Plans

Dependents who are covered by an absent parent's HMO and reside in the HMO's service area must receive covered *medical care from that HMO.*

Consider an HMO as unavailable if the dependent does not live in the area of the HMO or if they are unable to travel to it for their medical care. Consider them as uninsured until the Child Support Agency (CSA) can have them changed to a non-HMO plan. Complete the Health Insurance Information form (DES 2096) and give it to the CSA. Write on it in red "NOT ENTERED IN CARES – DISTANT HMO."

For the purpose of determining BC eligibility, consider this access to insurance.

38.5.2 Referral to CSA

Refer the absent parents of all clients, whether or not paternity has been established, to the CSA.

If the custodial parent is able to provide all the necessary health insurance information, enter that information into

38.5.2 Referral to CSA (cont.)

CARES. If s/he can only provide partial or no information, the CSA will contact the absent parent and obtain the needed information.

38.6.0 Health Insurance Risk Sharing Plan

The Health Insurance Risk Sharing Plan (HIRSP) is available for purchase by Wisconsin residents under age 65 who are not able to find adequate health insurance coverage in the private sector.

Advise MA clients who are covered by HIRSP that they must let Blue Cross/Blue Shield know immediately when they begin MA eligibility. To do this, contact:

Plan Administrator
Wisconsin Health Insurance Risk
Sharing Plan
6406 Bridge Road, Suite 18
Madison, WI 53784-0018

Telephone: 1-800-828-4777 or (608) 221-4551

38.7.0 Health Insurance Premium Payment (HIPP)

HIPP pays the employee's portion of the employer subsidized health care coverage. EDS determines if it is more cost effective to buy the employer's insurance or enroll them in BC or MAPP.

38.7.1 Cost Effective

To assess cost effectiveness, EDS checks:

1. If the employer pays 60-80% of the premium cost, **and**

2. For BC, that no one has been enrolled in the past six months in a HIPAA plan in which the policy owner is an AG member.

If these two criteria are met, then EDS looks at projected costs of the insurance premiums, co-insurance and deductibles. Those costs are then compared to the projected expense of paying for medical services directly through MA.

If it is cost-effective to buy the employer-subsidized insurance, the HIPP Unit will notify those clients who are required to enroll in an employer's health plan and provide

38.7.1 Cost Effective *(cont)*

additional information related to enrollment, coverage, and cooperation.

HIPP may pay the premium for a non-MA family member if that member needs to enroll in the group health plan inorder to obtain coverage for the MA client. MA will only pay for the premiums of the ineligible family member(s) and not any of their other cost sharing expenses (e.g. prescription co-pays). MA will continue to cover the employer's health insurance premium, deductibles and co-insurance for the MA client.

38.7.2 Participation in HIPP

Clients participating in HIPP will have MA as a backup. If the employer's health insurance does not cover something that MA does, then MA will pick up the payment.

38.7.3 Cooperation

To remain eligible for BC or MAPP, the adult whose employer can provide insurance must:

1. Cooperate in providing information necessary to assess cost-effectiveness, **and**

2. Agree to enroll and actually enroll in the employer's health care plan if the plan is determined to be cost-effective.

Failure to cooperate or enroll in the employer's plan is non-cooperation. The adult who could get insurance coverage is not eligible for BC or MAPP. If one adult fails to cooperate, it does not affect the spouse or children's MA eligibility.

The EDS HIPP unit worker will communicate HIPP non-cooperation directly to you. Enter the non-cooperation and the ineligible adult will close after the next adverse action.

38.7.4 Exceptions

Listed below are two exceptions to participating in HIPP:

1. Clients who are enrolled in a Special Managed Care Program (SMCP).

   Some examples of SMCP's are Independent Care Program, Elder Care Option Program, and Wraparound Milwaukee. Do not consider the client non-cooperative if s/he refuses to participate in HIPP while enrolled in a SMCP.

38.7.4 Exceptions (cont.)

The HIPP Unit will monitor the client's enrollment in SMCP's to determine the client's responsibility for HIPP participation.

2. A client who is unable to enroll in an employer's health plan on their own behalf.

   An example of this situation would be when a MAPP client's spouse is unwilling to enroll the client in their employer based health plan. Since the client's spouse has the cost-effective employer's health plan, but chooses not to enroll the MAPP client, the coverage under that plan is considered unavailable to the client.

38.7.5 Not Cost Effective

If it is not cost-effective to buy the employer-subsidized insurance, the client will be enrolled in MAPP or BC.

38.7.5.1 BadgerCare HMO Enrollment

If it is not cost-effective to buy the employer-subsidized insurance, EDS enrolls family members into a BadgerCare HMO. If only one HMO in an area accepts BC clients, s/he can choose to remain fee-for-service. If you indicate that the AG has access to insurance in CARES, EDS will not enroll them in a HMO until the HIPP test is completed.

38.8.0 TPL End Date

Each month EDS sends a Third Party Liability (TPL) Segment – End Date Report to all certifying agencies (38.11.0). The report lists cases that have an insurance end date that has been applied in the last month.

If EDS verifies a major medical policy has ended, EDS automatically updates CARES and sends an alert. The worker should:

1. Ask the client if the insurance has ended.

2. If the client says that the insurance listed has not ended, the information is considered questionable. Verify the insurance information and update CARES (AFMC and AFMI).

38.8.0 TPL End Date (cont.)

3. Run eligibility.

The information on the End Date Report is arranged in eight columns under the following numbers:

1. Name of the casehead.

2. Name of the insured person.

3. Insured person's MA ID number.

4. Name of the insurance policy holder.

5. Policy number. The name of the insurance carrier appears under the policy number.

6. The date on which coverage with the carrier named in #5 ended.

7. Who submitted the end date? If "INS CO" is listed, the insurance carrier provided the end date. If "AGENCY" is listed, the ESA or CSA provided the end date.

8. Indicates whether the person named in #2 has another insurance policy that is still in effect.

   If the open insurance policy (indicated in #8) is a drug or dental plan that was part of the terminated policy, it must also be ended.

When a TPL Segment ends, EDS allows medical bills that would have gone first to an insurance company to be reviewed immediately by MA for payment.

38.9.0 Double Payment

Sometimes EDS finds that services have been paid for by both MA and a third party that is not listed in the MA file. When this happens, the worker may receive a Coverage Discrepancy Report from EDS.

If you receive this notice, review your files and contact the client to find out the TPL status of the MA group members. If you find there is private health insurance available to any of the members, update CARES.

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38.10.0 Health Insurance Information Form

If CARES is not available, the Health Insurance Information form (DES 2096) can be used to collect insurance information. Complete a separate form for each insurance policy if a person has more than one. Listed below are some instructions for filling out this form.

IM/CS Blocks. If you can complete the form in its entirety, check IM. Do not check this box if you refer the form to Child Support for completion.

Added. Check the "Added" box when the policy in question has never been sent to EDS, and is not on their file. Complete the entire form.

Changed or Ended. Check the "Changed or Ended" box when altering information that is already on EDS's file and complete these items:

1. The shaded area on the top.

2. MA ID numbers and names of only those case members affected by the change. Date of birth is required. Relationship is not.

3. The insurance company name in Box 1.

4. The policy number in Box 6.

5. The policy start date in Box 9.

6. The information you want to change. For example, to report the date on which coverage terminated, enter the end date in Box 10.

Deleted. Check the "Deleted" box when removing insurance information.

Do not use a delete transaction in place of a change transaction when valid insurance coverage ends. Use it only if:

38.10.0 Health Insurance (cont.)

1. . The insurance data put on the file was not valid during a period of MA eligibility, **or**
2. The information should never have been put on the file because, for instance, it is life insurance.

To change the policy number, the insurance company billing address, or the start date of coverage, send EDS:

1. A DES 2096 marked "Delete" (on which you have deleted the incorrect information), **and**

2. A second DES 2096 marked "Add" (on which you have added the correct information).

Staple the forms together. Mark on the delete copy in red "1 of 2". Mark on the add copy in red "2 of 2".

When you are submitting a delete form with an add form, complete the add form in its entirety.

For the delete transaction, complete the shaded area on the top.

38.10.1 Section A

In Section A, list the MA ID numbers and the names of only those case members affected by the delete and their date of birth.

- Enter the insurance company name in Box 1.
- Enter the policy number in Box 6.
- Enter the policy start date in Box 9.

38.10.2 Section B

6. **Policy Number**. If the insurance ID card contains nothing but a group number, put the insured person's Social Security Number (SSN) in this space.

9. **Policy Start Date**. Use the effective date of the policy listed on the insurance ID card. If the date is not available, make the start date equal to or earlier than the start date of eligibility.

38.10.3 Section C

17. The policyholder's SSN is voluntary. Failure to provide your SSN may result in a processing delay.

38.10.4 Section D

If a retired client has insurance through a former employer, list that former employer and the address, if available.

38.10.5 Where to Send

Send the original to:

EDS - TPL Unit
P.O. Box 7636
Madison, WI 53707-7636

38.11.0 TPL Segment End Date Report Sample

06/26/02

III 1

THIRD PARTY LIABILITY SUBSYSTEM

*** ***

TITLE: HMKR559Q - TPL Segment End Date Report

FREQUENCY/MEDIA: Monthly/paper

FICHE HEADER: n/a

JOB NAME:

OBJECTIVE: The purpose of this report is to identify recipients that have had an end date applied to the TPL segment the previous month. the report is used by certifying agencies and child support as an aid to identify additional insurance coverage, or ensure child support enforcement when insurance coverage is court ordered. One copy of the report is produced and distributed by EDS to certifying and child support agencies.

ORGANIZATION: Sorted in ascending order by agency code, by absent parent code, by worker number, and then by case head name.

EXCLUSIONS/LIMITATIONS: Recipients having an end date changed in the last month, but currently not eligible for Medical Assistance are excluded. TPL segments which were deleted from the eligibility file are excluded. TPL segments end dated due to T and E link are also excluded. All other T-Segments having end dates applied during the current month are included.

FIELD DESCRIPTIONS:

ABSENT PARENT	Identifies the policyholder as a parent who is absent from the home. Absent parent code is converted as follows: 1 – yes 0 – no
COUNTY	Three-digit numeric code identifying the certifying agency and, in most cases, the county in which the agency is located. Descriptions of certifying agency codes can be found in Quick Reference.
AGENCY (AGC)	Two-digit numeric code identifying the specific W2 or non-W2 agency within a county. Description of agencies can be found in Quick Reference.
IM WORKER	Six-digit agency worker number from the recipient's B-segment.
CARES CASE	10-digit identifier assigned by CARES to a group of CARES eligible recipients.
	TPL origin code. One-byte. Identifies the system by which

06/26/02

Source: EDS Quick Reference Guide

38.11.0 TPL Segment End Date Report Sample (cont.) **III 2**

THIRD PARTY LIABILITY SUBSYSTEM

****

ORG	TPL was established. Valid values are C (CARES), K (KIDS), and M (MMIS).
INSTRUCTIONAL MESSAGE	A message informing each agency how to use the report.
CASE HEAD LAST FIRST	Casehead's last and first name (e.g., parent of a child).
RECIPIENT LAST FIRST	Name of individual receiving Medical Assistance services.
MA NUMBER	Recipient's 10-digit Medical Assistance identification number.
POLICY HOLDER LAST FIRST	Insured's last and first name from the end dated TPL segment.
POLICY NUMBER	Policy number for the end dated TPL segment.
ENDED POLICY	Name of the insurance carrier from the end dated TPL segment.
END DATE	Date the insurance ended from the TPL segment.
SOURCE	Written description of the source of update information as identified by the source code on the end dated TPL segment. The source codes are converted as follows: 1 – DHCF 2 - Insurance Company 3 – Unknown 4 - Child Support Agency 5 – Agency 6 – HIPP 7 – Insurance Disclosure
SECOND TPL SEGMENT	If a TPL segment on the recipient's file still exists with an open end date, the name of the insurance carrier is printed.

Source: EDS Quick Reference Guide

38.11.0 TPL Segment End Date Report Sample (cont.)

```
HMKR559Q                    WISCONSIN - TITLE XIX - ELIGIBILITY                    DATE - 062802          PAGE  2,055

                                TPL SEGMENT END DATE REPORT
  ABSENT PARENT - NO
  COUNTY: 052 - RICHLAND
  AGENCY: 00
  IM WORKER:   XRI025

                                          INSTRUCTIONAL MESSAGE

THE FOLLOWING INDIVIDUALS ARE CURRENTLY ELIGIBLE FOR MEDICAL ASSISTANCE.  THE MEDICAL ASSISTANCE FILE SHOWS THE TPL SEGMENT HAS
BEEN END DATED DURING THE PAST MONTH.  THE FIELD TITLED "SOURCE" SHOWS WHO SUBMITTED THE END DATE.  WHEN SOURCE SHOWS "AGENCY" IT
REFERS TO EITHER IM OR CS AGENCY.  THE FIELD TITLED "ORG" INDICATES THE SYSTEM WHICH FIRST ESTABLISHED THE TPL, "C" FOR CARES,
"K" FOR KIDS, OR "M" FOR MMIS.

THIS REPORT IS SORTED ACCORDING TO WHETHER BOX 17 OF THE 2096 THAT REPORTED THE INSURANCE WAS CHECKED ABSENT PARENT "YES" OR "NO".
SEE THE UPPER LEFT CORNER OF THIS PAGE.  IF "YES", A CS AGENCY SHOULD FOLLOW UP FOR COMPLIANCE WITH ANY SUPPORT ORDER AND REPORT
ANY REPLACEMENT POLICY.  CS SHOULD ALSO QUICKLY SCREEN THE "NO" SORT FOR ABSENT PARENT CASES, BECAUSE REPORTING ERRORS FREQUENTLY
OCCUR IN BOX 17. IM SHOULD CHECK WITH THE CASE HEAD AND REPORT ANY NEW POLICY, ESPECIALLY ON THE REPORT LABELED ABSENT PARENT "NO".

IF WE KNOW OF ANOTHER POLICY APPARENTLY NOW IN FORCE, THAT WILL SHOW UNDER THE TITLE "SECOND TPL SEGMENT".

QUESTIONS REGARDING THIS REPORT SHOULD BE DIRECTED TO THE TPL ELIGIBILITY UNIT - PO BOX 7636 - MADISON, WI 53707 OR (608) 221-4746.

   CASE HEAD            RECIPIENT                     POLICY HOLDER        POLICY NUMBER    END              SECOND
LAST        FIRST      LAST        FIRST     MA NUMBER  LAST        FIRST    ENDED POLICY     DATE   SOURCE  TPL SEGMENT
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